

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

9060
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. 791
(b) Township..... Primary Registration District No. 1002
(c) City St. Louis, Mo. (d) Street No. St. Ann's Hospital Registered No. 2543
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Male Danner
(a) Residence, No. St. NR Doniphan Mo
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF			
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>March 15, 1940</u>			
7. AGE	YEARS	MONTHS	DAYS
			IF LESS than 1 day, ... hrs. or ... min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.		
	9. Industry or business in which work was done, as saw mill, bank, etc.		
	10. Date deceased last worked at this occupation (month and year)		
			11. Total time (years) spent in this occupation
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>St. Louis Missouri</u>			
FATHER	13. NAME		
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)		
MOTHER	15. MAIDEN NAME <u>Margaret Danner</u>		
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Doniphan, Missouri</u>		
17. INFORMANT (ADDRESS) <u>Margaret Danner Doniphan Mo</u>			
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Calvary</u> DATE <u>3-18</u> 19 <u>40</u>			
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>William Fletcher 5301 Page</u>			
20. FILED <u>MAR 18 1940</u> <u>J. B. Butler</u> Local Registrar			

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 16, 1940

22. I HEREBY CERTIFY, That I attended deceased from 11:40 PM - 3-15, 1940 to 5:15 AM - 3-16, 1940
I last saw him alive on 3-16, 1940. Death is said to have occurred on the date stated above, at 5:15 A.M.
The principal cause of death and related causes of importance were as follows:
Atelactonic Congestion
Pre Maturity

Other contributory causes of importance:
None

Name of operation None Date of None
What test confirmed diagnosis? Polani Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury 19.....
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? NO
If so, specify John B. O'Neill M. D.
(Address) 1222 Marquette Tower Bldg

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

....., or by

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Notes: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING, (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.